


MDS in Adult Family Care Homes: MDS-ALS

CASE MIX TEAM
Revised August 2015



MDS-ALS Training: Agenda

- History of MDS-ALS
- Purpose
- Definitions
- Schedule of Assessments
- Case Mix Index, RUG groups
- MDS-ALS Assessment Tool
- Corrections
- Quality Indicators

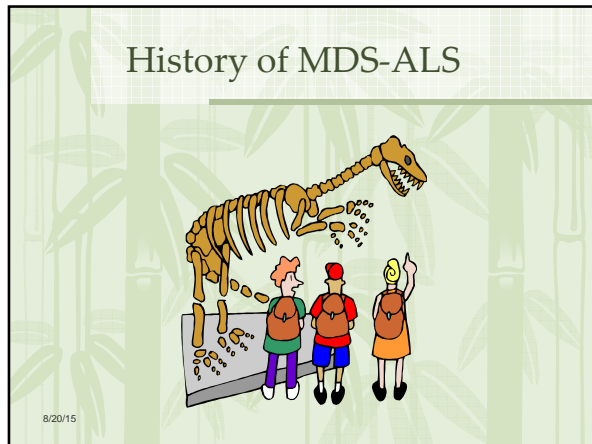
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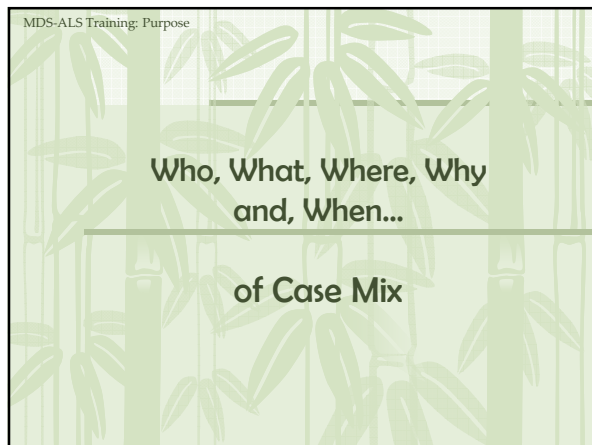
Training Requirement

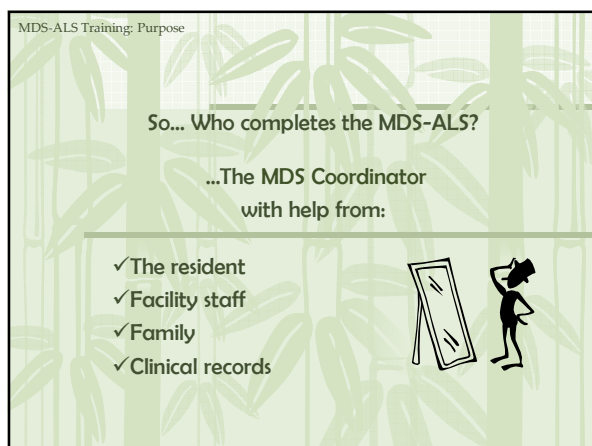
MaineCare Benefits Manual, Chapter II,
Section 2.07-1.A.4.a:


Only staff trained in completion of the
MDS-ALS *by the Department* may
conduct or coordinate assessments.

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Assessors Responsibilities

- Conduct interviews
- Read the manual
- Attend training
- Accuracy and timeliness
- Maintain confidentiality
- Edit and submit all MDS/ALS
- Review submission reports

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MDS-ALS Training: Purpose




And... What is Case Mix?

Case Mix is a system of reimbursement that pays facilities according to the amount of time spent providing care to residents.

Residents are grouped according to the amount of time needed to provide their care

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MDS-ALS Training: Purpose



And... Where is the assessment done?

MDS-ALS assessment is completed in the facility


- All residents
- Regardless of payer source

The MDS-ALS cannot be completed if the resident is not in the facility. For example, if in the hospital or on a therapeutic leave

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MDS-ALS Training: Purpose

And... Why do we need to do MDS-ALS Assessments?



1. To provide information to guide staff in developing a realistic individualized Service Plan.
2. To place a resident into a payment group within the Case Mix System.
3. To provide information that determines the Quality Indicators.
4. To show an accurate picture of the resident's condition, the type and amount of care needed

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MDS-ALS Training: Purpose


And... When are assessments done?

Type of Assessment	When Completed	Schedule
Admission Assessment	Initial Admission	By the end of the 30 th day after admission, as represented by the S2b date. Admission is day #1.
Semi Annual Assessment	Within 180 days of last comprehensive MDS-RCA	Within 7 days of assessment date entered in (A5), as represented by the S2b date.
Annual Assessment	Within 180 days of last MDS-RCA assessment	Within 7 days of assessment date entered in (A5), as represented by the S2b date.
Significant Change Assessment	Only if significant change has occurred	Assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred.
Other	When required by Case Mix Nurse	Within 7 calendar days of Case Mix Nurse visit as represented by S2b date.
Discharge Tracking Form	When a resident is discharged, transferred or deceased	Completed within 7 days of the event
MDS-ALS Face Sheet (Section AA through AD of the MDS-ALS form)	Provides key information to uniquely identify each resident and to track the resident in the automated system	Completed only once, at the time of admission to a facility.

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MDS-ALS Training: Timeliness and Accuracy

Timeliness



MaineCare Benefits Manual,
Chapter II, Section 2.07-1.A.8:

“The Department will sanction providers who fail to accurately complete assessments in a timely manner.”

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Accuracy

Documentation is required to support the time periods and information coded on the MDS-ALS. (MBM, chapter II, Section 2.07-1.A.4.c)

Penalty for Falsification: The Department may sanction a provider whenever the provider willfully and/or knowingly certifies (*or causes another individual to certify*) a material and false statement in an assessment. This may be in addition to any other penalties provided by statute.

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Case Mix



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Case Mix Quality Assurance Review




About every 6 months, a Case Mix nurse reviews a sample of MDS-ALS assessments and resident records to check the accuracy of the MDS-ALS assessments.

Insufficient, inaccurate or lack of documentation to support information coded on the MDS-ALS may lead to an error.

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MDS-ALS Training

Poor Documentation could mean...




Lower payment than the facility could be receiving, OR

Overpayment which could lead to re-payment to the State (Sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.

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Never do an inaccurate assessment to match inaccurate documentation

If, after interviewing staff and interviewing/observing the resident, you feel that the documentation is inaccurate, write a note in the record to explain and code the MDS/ALS accurately



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MDS-ALS Training: Sanctions


Sanctions:

2%	Error rate 34% or greater and less than 37%
5%	Error rate 37% or greater and less than 41%
7%	Error rate 41% or greater and less than 45%
10%	Error rate 45% or greater
10%	If requested reassessments not completed within 7 days

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MDS-ALS Training: Purpose

Case Mix Resident Classification Groups and Weights




There are a total of 8 case mix classification or RUG (Resource Utilization Groups) groups, including one default group used when a resident cannot be classified into one of the other classification groups.

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RUG Groups

RUG Code	ALS Score	ADL Score	IADL Score	Weight	Rate
AV2	ALS 7-9	ADL 7-28		1.657	\$74.55
AV1	ALS 7-9	ADL 0-6		1.210	\$54.44
AH2	ALS 5-6	ADL 7-28		1.360	\$61.19
AH1	ALS 5-6	ADL 0-6		1.027	\$46.20
AM2	ALS 2-4		IADL 12-18	0.924	\$41.57
AM1	ALS 2-4		IADL 10-11	0.804	\$36.17
AL1	ALS 2-4		IADL 0-9	0.551	\$24.79
BC1	Unclassified			0.551	\$24.79



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Documentation Guidelines

ALS	FIELD	COMMENTARY
B3	Cognitive Skills for Daily Decision Making	Documentation must be found in the record of the resident's ability to actively make decisions regarding tasks of daily living in the last 7 days.
E1a-r	Indicators of Depression	Evidence & observations of these indicators must be present in the resident's record within the last 30 days.
G5ac G5ag	Assist. with phoning Assist. with arranging transport.	Evidence within the record of the resident involvement in the activity. Document the level of independence that best represents the client's functioning & the type of assistance provided over 30 days.
H4	Use of incontinent supplies	Evidence within the record of resident's management of incontinence supplies within the last 14 days. (pads, briefs, ostomy, catheter)
O5f	Administration of OTC medications	Evidence within the record that the resident <u>DID NOT</u> administer OTC meds within the last 7 days.
O6	Medication Preparation & Administration	Evidence in the record that the resident prepared/administered <u>NONE, SOME or ALL</u> of their medications within the last 7 days.
P10	Physicians Order Changes	Include the number of DAYS that the Physician or authorized assistant changed the residents written, telephoned, or faxed orders within the last 14 days. <u>DOES NOT INCLUDE:</u> admission orders, return admission orders or orders without change.

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DOCUMENTATION for ADL Scores

ALS	FIELD	COMMENTARY
G1aa G1ba G1ca G1da G1ea G1fa G1ga	Bed mobility Transfer Locomotion Dressing Eating Toilet use Personal hygiene	All areas must be documented for all shifts within the last 7 days. Self Performance score only.


DOCUMENTATION for IADL & Bathing Scores

ALS	FIELD	COMMENTARY
G2	Bathing(SP)	Evidence about how the resident takes a full body bath. Code for most dependent within the last 7 days.
G5aa G5ab G5ad G5ae G5af G5ah G5aj	Arrange Shopping Shopping Manage Finances Manage cash/allow Prepares Snacks Light Housework Laundry	IADLs done with help or done by others. Evidence within the record of the level of independence that best represents the clients functioning and the type of assistance provided over 30 days.

Submitting the MDS-ALS

Completed MDS-ALS assessments are submitted within **30** days of completion to:


Catherine Gunn-Thiele
Muskie School of Public Service
PO Box 9300
Portland, Me. 04104-9300
Office Phone: 780-5576



MDS-ALS Training: Assessment Tool

MDS-ALS Assessment Tool

Section by Section



MDS-ALS Training: Assessment Tool

Section AA: Identification Information.

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1. RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2. GENDER	<input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female
3. BIRTHDATE	Month Day Year
4. RACE/ETHNICITY (Check only one)	<input type="checkbox"/> 1. American Indian/Alaskan Native <input type="checkbox"/> 4. Hispanic <input type="checkbox"/> 2. Asian/Pacific Islander <input type="checkbox"/> 5. White, not of Hispanic origin <input type="checkbox"/> 3. Black, not of Hispanic origin <input type="checkbox"/> 6. Other
5. SOCIAL SECURITY and MEDICARE NUMBERS (If a "P" box if no med. no.)	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6. FACILITY NAME AND PROVIDER NO.	a. Facility Name b. Provider No.
7. MAINECARE NO.	(Record a "+" if pending, "N" if not a MaineCare recipient)
8. SIGNATURE(S) OF PERSON(S) COMPLETING TRACKING FORM:	
a. Signatures	Title Section Date
b.	Date
c. DATE COMPLETED	Record date tracking form was completed. Month Day Year

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Face Sheet: Background Information
Completed at the time of the resident's initial admission to the facility.

Section AB: Demographic Information
Section AC: Customary Routine
Section AD: Face Sheet Signatures and dates

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Section A: Identification and Background information

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1. RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2. SOCIAL SECURITY and MEDICARE NUMBERS (If a "P" box if no med. no.)	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
3. FACILITY NAME AND PROVIDER NO.	a. Facility Name b. Provider No.
4. MAINECARE NO.	(Record a "+" if pending, "N" if not a MaineCare recipient)
5. ASSESSMENT DATE	Last day of observation period Month Day Year
6. REASON FOR ASSESSMENT	(Check primary reason for assessment) <input type="checkbox"/> 1. Admission assessment <input type="checkbox"/> 4. Semi-Annual <input type="checkbox"/> 2. Annual assessment <input type="checkbox"/> 5. Other (specify) <input type="checkbox"/> 3. Significant change in status assessment

MDS-ALS Training: Purpose

When to complete a Significant Change MDS-ALS assessment:

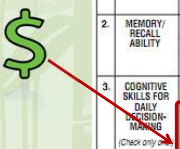


- Resident has experienced a “major change”
- Not self-limited
- Impacts more than one area of the resident’s clinical status
- Requires review and/or changes to the service plan
- Improvement or decline
- Completed by the end of the 14th day following the documented determination

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Section B: Cognitive Patterns




1. MEMORY (Recall of what was learned or known)	<p>a. Short-term memory OK—seems/appears to recall after 5 minutes</p> <p><input type="checkbox"/> 0. Memory OK <input type="checkbox"/> 1. Memory problem</p> <p>b. Long-term memory OK—seems/appears to recall long past</p> <p><input type="checkbox"/> 0. Memory OK <input type="checkbox"/> 1. Memory problem</p>
2. MEMORY/RECALL ABILITY (Check all that resident was normally able to recall during last 7 days)	<p>a. Current season <input type="checkbox"/> d. That he/she is in a facility/home</p> <p>b. Location of own room <input type="checkbox"/> e. NONE OF ABOVE are recalled</p> <p>c. Staff names/faces</p>
3. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (Made decisions regarding tasks of daily life) (Check only one)	<p><input type="checkbox"/> 0. INDEPENDENT—decisions consistent/reasonable</p> <p><input type="checkbox"/> 1. MODIFIED INDEPENDENCE—some difficulty in new situations only</p> <p><input type="checkbox"/> 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required</p> <p><input type="checkbox"/> 3. SEVERELY IMPAIRED—never/irregularly made decisions</p>
4. COGNITIVE STATUS (Check only one)	<p>Resident's cognitive status or abilities now compared to resident's status 180 days ago (or since admission if less than 180 days).</p> <p><input type="checkbox"/> 0. No change</p> <p><input type="checkbox"/> 1. Improved</p> <p><input type="checkbox"/> 2. Declined</p>

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SECTION C. COMMUNICATION/HEARING PATTERNS



1. HEARING (Check only one)	<p>(With hearing appliance, if used)</p> <p><input type="checkbox"/> 0. HEARS ADEQUATELY—normal talk, TV, phone</p> <p><input type="checkbox"/> 1. MINIMAL DIFFICULTY when not in quiet setting</p> <p><input type="checkbox"/> 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tone, quality and speak distinctly</p> <p><input type="checkbox"/> 3. HIGHLY IMPAIRED—absence of useful hearing</p>
2. COMMUNICATION DEVICES/TECHNIQUES (Check all that apply during last 7 days)	<p>a. Hearing aid, present and used</p> <p>b. Hearing aid, present and not used regularly</p> <p>c. Other receptive communication techniques used (e.g., lip reading)</p> <p>d. NONE OF ABOVE</p>
3. MAKING SELF UNDERSTOOD (Check only one)	<p>(Expressing information content—however able)</p> <p><input type="checkbox"/> 0. UNDERSTOOD</p> <p><input type="checkbox"/> 1. USUALLY UNDERSTOOD—difficulty finding words or forming thoughts</p> <p><input type="checkbox"/> 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests</p> <p><input type="checkbox"/> 3. RARELY/NEVER UNDERSTOOD</p>
4. ABILITY TO UNDERSTAND OTHERS (Check only one)	<p>(Understanding information content—however able)</p> <p><input type="checkbox"/> 0. UNDERSTANDS</p> <p><input type="checkbox"/> 1. USUALLY UNDERSTANDS—may miss some part / intent of message</p> <p><input type="checkbox"/> 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication</p> <p><input type="checkbox"/> 3. RARELY/NEVER UNDERSTANDS</p>

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SECTION D. VISION PATTERNS

1. **VISION** (Check only one.) (Ability to see in adequate light and with glasses if used)

☐ 0. **ADEQUATE**—sees fine detail, including regular print in newspapers/books

☐ 1. **IMPAIRED**—sees large print, but not regular print in newspapers/books

☐ 2. **MODERATELY IMPAIRED**—limited vision; not able to see newspaper headlines, but can identify objects


☐ 3. **HIGHLY IMPAIRED**—object identification in question, but eyes appear to follow objects

☐ 4. **SEVERELY IMPAIRED**—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects

2. **VISUAL APPLIANCES**


a. Glasses, contact lenses ☐ 0. No ☐ 1. Yes

b. Artificial eye ☐ 0. No ☐ 1. Yes



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SECTION E. MOOD and BEHAVIOR PATTERNS

1. **INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD** (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)

0. Not exhibited in last 30 days

1. This type of behavior exhibited up to 5 days a week (a minimum of 4 times per month)

2. This type of behavior exhibited daily or almost daily (6, 7 days/week)

VERBAL EXPRESSIONS OF DISTRESS

☐ a. Resident made negative statements—e.g., "Nothing matters. I'd just rather be dead. What's the use. Regrets having lived so long. Let me die."

☐ b. Repetitive questions—e.g., "Where do I go. What do I do?"

☐ c. Repetitive verbalizations—e.g., calling out for help, ("God help me")

☐ d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility, anger at care received

☐ e. Self-deprecation—e.g., "I am nothing. I am of no use to anyone"

☐ f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

☐ g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

☐ h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

☐ i. Repetitive anxious complaints/concerns (non-health related)—e.g., persistently seeks attention/resources regarding amenities, meals, laundry, clothing, relationship issues

(continued next page)

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Section E: Mood and Behavior Patterns (cont.)

1. **INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD** (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)

0. Not exhibited in last 30 days

1. This type of behavior exhibited up to 5 days a week (a minimum of 4 times per month)

2. This type of behavior exhibited daily or almost daily (6, 7 days/week)

SLEEP-CYCLE ISSUES

☐ j. Unpleasant mood in morning

☐ k. Irregular change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

☐ l. Sad, pained, worried facial expressions—e.g., furrowed brows

☐ m. Crying, tearfulness

☐ n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST


☐ o. Withdrawal from activities of interest—e.g., no interest in long-standing activities or being with family/friends

☐ p. Reduced social interaction

INDICATORS OF MANIA


☐ q. Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc.

☐ r. Excited behavior, motor excitation (e.g., heightened physical activity, excited, loud or pressured speech; increased reactivity)



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SECTION F. PSYCHOSOCIAL WELL-BEING

1. **SENSE OF INITIATIVE/ INVOLVEMENT**
(Check all that apply)

☐ a. At ease interacting with others

☐ b. At ease doing planned or structured activities

☐ c. At ease doing self-initiated activities

☐ d. Establishes own goals

☐ e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)

☐ f. Accepts invitations into most group activities

☐ g. NONE OF ABOVE

2. **UNSETTLED RELATIONSHIPS**
(Check all that apply)

☐ a. Coverston conflict with or repeated criticism of staff

☐ b. Unhappy with roommate

☐ c. Unhappy with residents other than roommate

☐ d. Openly expresses conflict/anger with family/friends

☐ e. Absence of personal contact with family/friends

☐ f. Recent loss of close family member/friend

☐ g. Does not adjust easily to change in routines

☐ h. NONE OF ABOVE

3. **LIFE- EVENTS HISTORY**
(Check all that apply)

☐ i. Events in past 2 years

☐ j. Serious accident or physical illness

☐ k. Health concerns for other person

☐ l. Death of family member or close friend

☐ m. Trouble with the law

☐ n. Robbed/physically attacked

☐ o. Conflict laden or severed relationship

☐ p. Loss of income leading to change in lifestyle

☐ q. Sexual assault/abuse


☐ r. Child custody issues

☐ s. Change in marital/partner status

☐ t. Review hearings (e.g., forensic, certification, capacity/hearing)

☐ u. NONE OF ABOVE

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ADL SELF-PERFORMANCE

Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days.

SECTION G. PHYSICAL FUNCTIONING

1. **(A) ADL SELF-PERFORMANCE**

0. **INDEPENDENT**—No help or oversight—OR— Help/oversight provided only 1 or 2 times during last 7 days

1. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days

2. **LIMITED ASSISTANCE**—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times—OR— Limited assistance (3 or more times), plus weight-bearing support provided only 1 or 2 times

3. **EXTENSIVE ASSISTANCE**—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days

4. **TOTAL DEPENDENCE**—Full staff performance of activity during last 7 days

5. **ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS**

6. **(B) ADL SUPPORT CODES (CODE for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD) during last 7 days; code regardless of person's self-performance classification.**


	A	B
0. No setup or physical help from staff		
1. Setup help only		
2. One-person physical assist		
3. Two-person physical assist		
4. Activity did not occur during entire 7 days		

7. **SELF-PERFORMANCE**

8. **SUPPORT**

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(A) ADL SELF-PERFORMANCE

0. **INDEPENDENT**—No help or oversight—OR— Help/oversight provided only 1 or 2 times during last 7 days

1. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days

2. **LIMITED ASSISTANCE**—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times—OR— Limited assistance (3 or more times), plus weight-bearing support provided only 1 or 2 times

3. **EXTENSIVE ASSISTANCE**—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days

4. **TOTAL DEPENDENCE**—Full staff performance of activity during last 7 days

5. **ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS**

6. **(B) ADL SUPPORT CODES (CODE for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD) during last 7 days; code regardless of person's self-performance classification.**

	A	B
0. No setup or physical help from staff		
1. Setup help only		
2. One-person physical assist		
3. Two-person physical assist		
4. Activity did not occur during entire 7 days		

7. **SELF-PERFORMANCE**

8. **SUPPORT**

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G2. Bathing Self -Performance

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) **Check for most dependent in self-performance** during last 7 days.

- ☐ 0. Independent—No help provided
- ☐ 1. Supervision—Oversight help only
- ☐ 2. Physical help limited to transfer only
- ☐ 3. Physical help in part of bathing activity
- ☐ 4. Total dependence
- ☐ 8. Activity itself did not occur during entire 7 days



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G5. IADL Self-Performance



- | | |
|--|--|
| a. Resident arranged for shopping for clothing, snacks, other incidentals. | |
| b. Resident shopped for clothing, snacks, or other incidentals. | |
| c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements. | |
| d. Resident managed finances including banking, handling checkbook, or paying bills. | |
| e. Resident managed cash, personal needs allowance. | |
| f. Resident prepared snacks, light meals. | |
| g. Resident used phone. | |
| h. Resident did light housework such as making own bed, dusting, or taking care of belongings. | |
| i. Resident sorted, folded, or washed own laundry. | |

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Note: this section has a **14-day** look back period.

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SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES (check for resident's PERFORMANCE OVER ALL 14 DAYS)			
0. CONTINENT—Complete control (includes use of indwelling urinary catheter or urinary device that does not leak urine or stool)			
1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly			
2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week			
3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2-3 times a week			
4. INCONTINENT—had inadequate control BLADDER, multiple daily episodes; BOWEL, all or almost all of the time			
a. BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed		
b. BLADDER CONTINENCE	Control of urinary bladder function with appliances (e.g. Foley) or continence programs, if employed		
2. BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days Constipation	Diarrhea Fecal impaction Resident is incontinent NONE OF ABOVE	
5. APPLIANCES OR PROGRAMS	Any scheduled toileting plan Bladder retaining program External (condom) catheter Indwelling catheter Incontinent catheter	Did not use toilet room/commode/urinal Pads/briefs used Enemas/irrigation Catheter present NONE OF ABOVE	
4. USE OF INCONTINENCE SUPPLIES (check only one)			
0. Always continent			
1. Resident incontinent and able to manage incontinence supplies independently			
2. Resident incontinent and receives assistance with managing incontinence supplies			
3. Resident incontinent and does not use incontinence supplies			

H4. Use of Incontinence Supplies



0. Always Continent

1. Resident incontinent and able to manage supplies independently.
2. Resident incontinent and receives assistance with managing supplies.
3. Resident incontinent and does not use incontinence supplies. For example, resident refuses to use the supplies or hides their soiled garments.

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POP QUIZ !

0 - Continent – Complete control

1 - Usually Continent – Bladder, incontinent episodes occur once a week or less. Bowel incontinent episodes occur less than once a week.

2 - Occasionally Incontinent – Bladder incontinent episode occur two or more times a week but not daily. Bowel incontinent episodes occur once a week.

3 - Frequently Incontinent – Bladder, tended to be incontinent daily, but some control present (e.g., on day shift) Bowel, 2-3 times a week.

4 - Incontinent – Bladder incontinent episodes occur multiple times daily. Bowel incontinence is all (or almost all) of the time.

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A. Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet.

B. Mr. R had an indwelling catheter in place during the entire 14-day assessment period. He was never found wet.

C. Although she is generally continent of urine, every once in a while (about once in two weeks) Mrs. T doesn't make it to the bathroom in time after receiving her daily diuretic pill

D. Late in the day when she is tired, Mrs. A sometimes (but not all days) has more episodes of urinary incontinence.

MDS-ALS Training: Assessment Tool

Section I: Diagnosis



All diseases and conditions must have physician documented diagnosis in the clinical record.

Do not include conditions that have been resolved or no longer affect the resident's functioning or service plan.




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MDS-ALS Training: Assessment Tool

Section J covers Health Conditions and Possible Medication Side Effects...

A lot of territory!

- J1. Problem conditions
- J2. Extrapyrimal signs and symptoms
- J3 and 4. Pain Symptoms and location
- J5 and 6. Pain interference and management
- J7. Accidents
- J8. Fall risk



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Section J. Health Conditions and Possible Medication Side Effects

SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS

(Check all problems present in last 7 days unless other time frame is indicated)

1. PROBLEM CONDITIONS
<input type="checkbox"/> a. Inability to lie flat due to shortness of breath
<input type="checkbox"/> b. Shortness of breath
<input type="checkbox"/> c. Edema
<input type="checkbox"/> d. Dizziness/vertigo
<input type="checkbox"/> e. Delusions
<input type="checkbox"/> f. Hallucinations
<input type="checkbox"/> g. Hostility
<input type="checkbox"/> h. Suspiciousness
<input type="checkbox"/> i. Headache
<input type="checkbox"/> j. Numbness/tingling
<input type="checkbox"/> k. Blurred vision
<input type="checkbox"/> l. Dry mouth
<input type="checkbox"/> m. Excessive salivation or drooling
<input type="checkbox"/> n. Change in normal appetite
<input type="checkbox"/> o. Other (specify) _____
<input type="checkbox"/> p. NONE OF ABOVE



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Section K: Oral and Nutritional Status


SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS (Check all that apply)
<input type="checkbox"/> a. Mouth is "dry" when eating a meal
<input type="checkbox"/> b. Chewing Problem
<input type="checkbox"/> c. Swallowing Problem
<input type="checkbox"/> d. Mouth Pain
<input type="checkbox"/> e. NONE OF ABOVE

2. HEIGHT AND WEIGHT
Record (a.) height in inches and (b.) weight in pounds. Use weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.
a. HT (in) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
b. WT (lb) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>


3. WEIGHT CHANGE
a. Unintended weight loss—5% or more in last 30 days; or 10% or more in last 180 days
<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
b. Unintended weight gain—5% or more in last 30 days; or 10% or more in last 180 days
<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

4. NUTRITIONAL PROBLEMS OR APPROACHES (Check all that apply)
<input type="checkbox"/> a. Complaints about the taste of many foods
<input type="checkbox"/> b. Regular or repetitive complaints of hunger
<input type="checkbox"/> c. Leaves 25% of food uneaten at most meals
<input type="checkbox"/> d. Therapeutic diet
<input type="checkbox"/> e. Mechanically altered (or pureed) diet
<input type="checkbox"/> f. Noncompliance with diet
<input type="checkbox"/> g. Eating disorders
<input type="checkbox"/> h. Food allergies (specify) _____
<input type="checkbox"/> i. Restrictions (specify) _____
<input type="checkbox"/> j. NONE OF ABOVE



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Section L: Oral / Dental Status

SECTION L. ORAL/DENTAL STATUS

1. ORAL STATUS AND DISEASE PREVENTION <i>(Check all that apply.)</i>	<input type="checkbox"/> a. Has dentures or removable bridge
	<input type="checkbox"/> b. Some/all natural teeth lost—does not have or does not use dentures (or partial plates)
	<input type="checkbox"/> c. Broken, loose or carious teeth
	<input type="checkbox"/> d. Inflamed gums (gingivitis); swollen or bleeding gums; oral abscesses; ulcers or rashes
	<input type="checkbox"/> e. Daily cleaning of teeth/dentures or daily mouth care—by resident or staff
	<input type="checkbox"/> f. Resident has difficulty brushing teeth or dentures
	<input type="checkbox"/> g. NONE OF ABOVE

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Section M: Skin Condition

SECTION M. SKIN CONDITION

1. SKIN PROBLEMS <i>(Check all that apply.)</i>	Any troubling skin conditions or changes in the last 7 days?		
	<input type="checkbox"/> a. Abrasions (scrapes) or cuts <input type="checkbox"/> b. Burns (2nd or 3rd degree) <input type="checkbox"/> c. Bruises <input type="checkbox"/> d. Rashes, itchiness, body lice	<input type="checkbox"/> e. Open sores or lesions <input type="checkbox"/> f. Other (specify): <input type="checkbox"/> g. NONE OF ABOVE	
2. ULCERS <i>(Due to any cause)</i>	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9-11 or more. Requires full body exam.)	Number at Stage	
	a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved		
	b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater		
	c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue		
	d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone		
3. FOOT PROBLEMS	a. Resident or someone else inspects resident's feet on a regular basis? <input type="checkbox"/> a. No <input type="checkbox"/> 1. Yes		
	b. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, enlarged toe in last 7 days? <input type="checkbox"/> a. No <input type="checkbox"/> 1. Yes		

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Section N: Activity Pursuit Patterns

SECTION N. ACTIVITY PURSUIT PATTERNS




1. TIME AWAKE	<i>(Check appropriate time periods over last 7 days)</i> Resident awakes all or most of time (i.e., naps no more than one hour per time period) in the: <input type="checkbox"/> a. Morning <input type="checkbox"/> d. Night (Bedtime to A.M.) <input type="checkbox"/> b. Afternoon <input type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Evening
2. AVERAGE TIME INVOLVED IN ACTIVITIES <i>(Check only one.)</i>	<i>(When awake and not receiving treatments or ADL care)</i> <input type="checkbox"/> 1. Most—more than 2/3 of time <input type="checkbox"/> 2. Some—from 1/3 to 2/3 of time <input type="checkbox"/> 3. Little—less than 1/3 of time <input type="checkbox"/> 4. None
3. PREFERRED ACTIVITY SETTINGS	<i>(Check all settings in which activities are preferred)</i> <input type="checkbox"/> a. Own room <input type="checkbox"/> d. Away from facility <input type="checkbox"/> b. Day/activity room <input type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Outside facility (e.g., in yard)
4. GENERAL ACTIVITY PREFERENCES	<i>(Check all PREFERENCES whether or not activity is currently available to resident)</i> <input type="checkbox"/> a. Cards/other games <input type="checkbox"/> k. Gardening or plants <input type="checkbox"/> b. Crafts/arts <input type="checkbox"/> l. Talking or conversing <input type="checkbox"/> c. Exercise/sports <input type="checkbox"/> m. Helping others

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Section P: Special Treatments and Procedures (cont.)

3. NEED FOR ON-GOING MONITORING	(Code for person responsible for monitoring)	
	0. No monitoring required	2. RCF Other Staff
	1. RCF nurse	3. Home health nurse
_____ a. Acute physical or psychiatric condition - not chronic		_____ b. New treatment/medication



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Section P: Special Treatments and Procedures

P4. Rehab / Restorative care



P5. Skill Training

P6. Adherence With Treatments/Therapies Programs

P7. General Hospital Stays

P8. Emergency Room (ER) Visit(s)

P9. Physician Visits




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Section P: Special Treatments and Procedures

10. **PHYSICIAN ORDERS** In the **last 14 days** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter "0" if none)


Note: Code the number of **days** the physician changed the resident's orders, not including order renewals without Change or clarification of orders.



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Section P: Special Treatments and Procedures



P11. Abnormal Lab Values

P12. Psychiatric Hospital Stay(s)


P13. Outpatient Surgery



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Section Q: Service Planning



SECTION Q. SERVICE PLANNING

1. RESIDENT GOALS <i>(Check all areas in which resident has self-identified goals)</i>	<input type="checkbox"/> a. Health promotion/wellness/exercise <input type="checkbox"/> b. Social involvement/making friends <input type="checkbox"/> c. Activities/hobbies/adult learning <input type="checkbox"/> d. Rehabilitation-skilled <input type="checkbox"/> e. Maintaining physical or cognitive function <input type="checkbox"/> f. Participation in the community <input type="checkbox"/> g. Other (specify) _____ <input type="checkbox"/> h. No goals
2. CONFLICT	<p>a. Any disagreement between resident and family about goals or service plan? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p> <p>b. Any disagreement between resident/family and staff about goals or service plan? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p>

Note: this item refers to Resident self-identified goals


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MDS-ALS Training: Assessment Tool

Section R: Discharge Potential

SECTION R. DISCHARGE POTENTIAL

1. DISCHARGE POTENTIAL	<p>a. Does resident or family indicate a preference to return to community? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p> <p>b. Does resident have a support person who is positive towards discharge? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p> <p>c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months? <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined</p>
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Section S: Assessment Information and Signatures

SECTION S. ASSESSMENT INFORMATION

1. **PARTICIPATION IN ASSESSMENT**

a. Resident: ☐ 0. No ☐ 1. Yes

b. Family: ☐ 0. No ☐ 1. Yes ☐ 2. No Family

c. Other Non-Staff: ☐ 0. No ☐ 1. Yes ☐ 2. None

2. **SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:**

a. Signature of Assessment Coordinator (sign on line above)

b. Date Assessment Coordinator signed as complete

____/____/____

c. Other Signatures Title Sections Date


d. Date

e. Date

3. **CASE MIX GROUP**

☐ ☐ ☐ ☐ ☐


Section T: Preventive Health



SECTION T. PREVENTIVE HEALTH MEASUREMENTS

1. PREVENTIVE HEALTH *(Check all the procedures the resident received during the past 12 months)*

<input type="checkbox"/> a. Blood pressure monitoring	<input type="checkbox"/> g. Breast exam or mammogram
<input type="checkbox"/> b. Hearing assessment	<input type="checkbox"/> h. Pap smear
<input type="checkbox"/> c. Vision test	<input type="checkbox"/> i. PSA or rectal exam
<input type="checkbox"/> d. Dental visit	<input type="checkbox"/> j. Other (specify) _____
<input type="checkbox"/> e. Influenza vaccine	
<input type="checkbox"/> f. Pneumococcal vaccine (ANY time)	



Note: 12 month look back period for preventive health measures.

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Section U: Medications list

SECTION II. MEDICATIONS LIST					
Use all medications given during the last 7 days. Include medications used regularly and those given only at the resident's healthcare regimen.					
1. List the medication name and dosage					
2. Route of administration. Use the appropriate code from the following list:					
1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (Subcut)	7 = topical	9 = enteral tube	
2 = buccal (BU)	4 = intravenous (IV)	6 = rectal	8 = inhaled	10 = other	
3. FREQUENCY. List the appropriate frequency code to show the number of times each medication was given (use the medication name only)					
PR = (PRN) as needed	8D = daily every eight hours	SD = 1 time a day	SD = 1 time every seven days		
2D = 2 times every two hours	1D = 1 time every day	2D = 2 times every two days	SD = 1 time every seven days		
3D = 3 times every three hours	3D = 3 times every three days	3D = 3 times every three days	SD = 1 time every seven days		
4D = 4 times every four hours	4D = 4 times every four days	4D = 4 times every four days	SD = 1 time every seven days		
5D = 5 times every five hours	5D = 5 times every five days	5D = 5 times every five days	SD = 1 time every seven days		
6D = 6 times every six hours	6D = 6 times every six days	6D = 6 times every six days	SD = 1 time every seven days		
7D = 7 times every seven hours	7D = 7 times every seven days	7D = 7 times every seven days	SD = 1 time every seven days		
8D = 8 times every eight hours	8D = 8 times every eight days	8D = 8 times every eight days	SD = 1 time every seven days		
9D = 9 times every nine hours	9D = 9 times every nine days	9D = 9 times every nine days	SD = 1 time every seven days		
10D = 10 times every ten hours	10D = 10 times every ten days	10D = 10 times every ten days	SD = 1 time every seven days		
4. PRN (yes – number of doses) / If the frequency code is "PRN," record the number of times during the past 7 days that each PRN medication was given. Do not use the time column for scheduled medications.					
5. DRUG CODE. Enter the National Drug Code (NDC). The last two digits of the 11-digit NDC define package size and have been omitted from the codes listed in the National Resident Assessment Instrument. The NDC should be entered last two digits of the code should be entered in the space marked the end of the NDC column. This should result in the last two spaces being left blank.					
1. Medication Name and Dosage	2. RA	3. Freq	4. PRN/yes	5. NDC Codes	
EXAMPLE: Coumadin 5 mg	1	1W			
Pigment 0.15% eye	1	1D			
Humulin R 25 Units	5	1D			
Humulin 150c	1	PR	2		

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MDS-ALS Training: Discharge Tracking Tool

DISCHARGE FORM

SECTION 01. IDENTIFICATION INFORMATION

1. RESIDENT NAME
a. First b. (Middle initial) c. (Last) d. (U/S)

2. GENDER
1. Male 2. Female

3. BIRTHDATE
Month Day Year

4. RACE / ETHNICITY
(Check only one)
1. American Indian/Alaskan Native 2. White, not of Hispanic origin
3. Asian/Pacific Islander 4. Black, not of Hispanic origin 5. Other
6. Hispanic

5. SOCIAL SECURITY AND MEDICARE NUMBERS
(a) Social Security Number
(b) Medicare number (or comparable railroad insurance number)

6. FACILITY NAME AND PROVIDER NO.

SECTION 02. ASSESSMENT/DISCHARGE INFORMATION

1. DISCHARGE STATUS
Date for resident's disposition upon discharge:
1. Private home/care with no home health services
2. Private home/care with home health services
3. Another residential care facility (specify) _____
4. Nursing home (specify) _____
5. Acute care hospital
6. Psychiatric hospital / MROD facility
7. Rehabilitation hospital
8. Deceased
9. Other (specify) _____

2. DISCHARGE DATE
Date of death or discharge
Month Day Year

3. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:
a. Signatures Title Date
b. _____ Case Date
c. _____ Case Date

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Scoring of the MDS-ALS

3 step process:

1. Calculate ALS (Assisted Living Score)
2. Calculate ADL score
3. Calculate IADL / Bathing (IADL/B) score

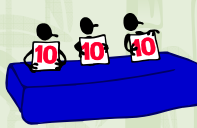
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Step 1: Calculate Daily Living Skills Score

Modified Cognitive Skills	If value B3-D4 then Score=1, otherwise Score=0
B3 Cognitive skills for daily decision-making	Count number of items in Section B1 that are 10. If total count is 0, 1 or 2 then Score = 0. If total count is 3 or more, then score = 1 in the B3-D4 score area
Indicators of Depression, Anxiety, and/or Bad Mood	
E1a Negative statements	
E1b Repetitive questions	
E1c Repetitive statements	
E1d Repetitive anger with self or others	
E1e Self-deprecation	
E1f Statements of guilt or appearance of concern/tears	
E1g Recurrent statements that something terrible is about to happen	
E1h Repetitive health concerns	
E1i Repetitive emotional complaints	
E1j Mood in morning, unpleasant	
E1k Inconsistently or absent smile pattern	
E1l Self, partner, interest facial expressions	
E1m Crying, persistent	
E1n Repetitive physical movements	
E1o Withdrawal from activities of interest	
E1p Reduced social interaction	
E1q Sleep pattern	
E1r Exaggerated behavior, motor excitation	
Total	
Assistance with use of the telephone or arranging transportation	If value G5a or G5a+1 or 2, Score = 0 in the shared score area, otherwise enter 0 in the shared area
G5a1 Transportation	
G5a2 Assistance to use telephone	
Total	
Management of Incontinence Supplies	F1a-D3 Score=0; F1a-D3 Score=1; F1a-D3 Score=2; F1a-D3 Score=3
H4 Ability to manage incontinent supplies	
Self-Administration of Medications	If D5H1, Score = 0. Otherwise Score = 1.
D5H Self-administration of over the counter medications	
Medication Preparation and Administration	F1D3D4 Score=0; F1D3H1 Score=0; F1D3H2 Score=1; F1D3H3 Score=2
D5H1 Did resident prepare and administer any of his/her own medications	
Physician's Orders	If value P1D3D4, Score=1. Otherwise Score=0
P1D3 Number of days physician changed orders	

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Living Assistance Score



ADL Score

Step 2: Calculate ADL score	
Activities of Daily Living (ADL)	If response = 0, Score 0; If response = 1, Score 1; If response = 2, Score 2; If response = 3, Score 3; If response = 4, Score 4; If response = 8, Score 4;
G1Aa Bed mobility, self-performance	
G1Ba Transfer, self-performance	
G1Ca Locomotion, self-performance	
G1Da Dressing, self-performance	
G1Ea Eating, self-performance	
G1Fa Toilet Use, self-performance	
G1Ga Personal hygiene, self-performance	
Total all ADL items to calculate ADL score	

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IADL / Bathing Score

Step 3: Instrumental Activities of Daily Living and Bathing (IADL/B)	
Bathing	If G2 = 0, Score=0; If G2 = 1, Score=1; If G2 = 2, Score=2; If G2 = 3, Score=3; If G2 = 4, Score=4; If G2 = 8, Score=0;
G2 Bathing, self-performance	
Instrumental Activities of Daily Living	If response = 0, Score=0; If response = 1, Score=1; If response = 2, Score=2; If response = 3, Score=3; If response = 4, Score=4; If response = 8, Score=0;
G5Aa Arranging for shopping	
G5Ab Shopping	
G5Ad Managing finances	
G5Ae Managing cash, allowance	
G5Af Prepares snack	
G5Ah Light housework	
G5Ai Laundry	
Total IADL	
Total IADL and Bathing (IADL/B)	

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Final RUG Score

MaineCare Adult Family Care Home RUG group: Use scores from Living Assistance Score and the higher of ADL and IADL/B scores to determine classification group from chart below.

RUG code					
RUG Code	ALS Score	ADL Score	IADL Score	Weight	Rate
AV2	ALS 7-9	ADL 7-28		1.657	\$71.68
AV1	ALS 7-9	ADL 0-6		1.210	\$52.34
AH2	ALS 5-6	ADL 7-28		1.360	\$58.83
AH1	ALS 5-6	ADL 0-6		1.027	\$44.43
AM2	ALS 2-4		IADL 12-18	0.924	\$39.97
AM1	ALS 2-4		IADL 10-11	0.804	\$34.78
AL1	ALS 2-4		IADL 0-9	0.551	\$23.84
BC1	Unclassified			0.551	\$23.84

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